SECTION 2

DENTAL SERVICES

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1 GENERAL POLICY

Dental services, as specified in this section, are a covered service of the Utah Medicaid Program. References: 42 C.F.R. 440.100, 440.120, 442.457, 442.458, 447.341, 483.460; Utah Department of Health Rule R455-20B.

Non-pregnant Adults Age 21 and Older

For non-pregnant adults age 21 and older, Medicaid will reimburse only for limited, emergency dental services. These include one limited oral evaluation, problem focused; an intraoral - periapical - first film, and an extraction, single tooth. Refer to Chapters 1 - 5, Diagnostic Services; 1 - 6, Radiographic Services, and 1 - 13, Oral Surgery.

Children, ages 0 through 20 and Pregnant Women

Children from birth through age 20 and pregnant women continue to be covered for the services described in SECTION 2, Dental Care Services.

1 - 1 Credentials

Dentists licensed in the state where the services are provided may be reimbursed for services.

1 - 2 Billing

Dental services are billed using ADA accepted dental claim forms. Medicaid can only accept up to 18 procedure code lines per claim form. For detailed instructions for completion of the dental claim forms, refer to the instructions included with this manual.

1 - 3 Definitions

Adult: A person who is 21 years of age or older on the date of service.

Child: A person who is age 20 or under on the date of service.

Dental Services: Diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession.

Dentist: An individual licensed to practice dentistry.

Anterior Tooth: Tooth numbers 6 through 11; 22 through 27; C through H; and M through R.

Posterior Tooth: Tooth numbers 1 through 5; 12 through 21; 28 through 32 and A through B; I through L; and S through T.

Prior authorization: Prior authorization is approval given by the Division of Health Care Financing prior to dental services being rendered.

If a dental code requires prior authorization, the procedure must be authorized by Medicaid BEFORE the service is given, except for emergency services. Emergency services may be approved after the service is given if adequate documentation of the emergency is included with the request.

1 - 4 Covered Services and Limitations

Dental services covered by Medicaid are described in Chapters 1 - 5 through 1 - 18. Services ***not*** described, or listed in Chapter 2, Non-Covered Services, are ***not*** covered. Services covered for all patients are listed under the general service heading.

1 - 5 Diagnostic Services

Non-pregnant adults age 21 and older

For non-pregnant adults age 21 and older, Medicaid will reimburse for only one limited oral evaluation, problem focused. Medicaid considers this an emergency exam and will allow this code with x-rays, no more than two extractions (for pain relief), and other limited procedures to relieve pain in an emergency situation. Use code D0140 to bill. For adults, only three other codes are covered:

- D0220, Intraoral - periapical - first film
- D7110, Extraction, single tooth
- D7210, Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of the tooth

Only one limited evaluation per patient per day is covered, even if more than one provider is involved from the same office or clinic. **Multi-exams for the same date of service are not covered**.

Children, ages 0 through 20 and pregnant women

Medicaid will reimburse for only one evaluation (D0140, D0120, or D0150) per patient per day, even if more than one provider is involved from the same office or clinic. Multi-exams for the same date of service are not covered.

Code D0140 is **not** to be billed with numerous fillings, multi-tooth extractions, prophy and fluoride treatments, relines, root canals, reline, denture appointments, nor regular examinations. A comprehensive oral evaluation is a covered service payable one time only per provider.

A limited oral evaluation - problem focused is also a covered service. See policy for use of code D0140 under the heading above “Non-pregnant adults Age 21 and Older.”

A periodic oral evaluation is a covered service and may be performed twice in a calendar year per patient. This is allowed two times by the same provider, or one time when it is performed in addition to a previously administered comprehensive oral evaluation.

1 - 6 Radiographic Services

Non-pregnant adults age 21 and older

For non-pregnant adults age 21 and older, Medicaid will reimburse for only an intraoral - periapical - first film in conjunction with an emergency exam. Refer to Chapter 1 - 5, Diagnostic Services. Use code D0220, Intraoral - periapical - first film, to bill.

Children, ages 0 through 20 and pregnant women

The following types of radiographic procedures are covered: Bitewing; Periapical; Full Mouth Series; Panoramic.

1. Medicaid considers it standard practice to bill for a full mouth series if more than 12 periapicals are taken during a single visit. If the number of x-rays exceed 12 per visit, they rebundle into code D0210, full mouth series.
2. A panoramic x-ray with more than bitewings, 2 or 4 films, plus 2 periapicals will rebundle to D0210.
3. Any periapical x-rays billed additionally with D0210 will be rebundled and considered part of the full mouth series.
4. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
5. Panoramic x-rays and full series x-rays should not be taken more often than one every two years unless there is specific dental diagnostic need documented in the patient’s records.

1 - 7 Preventive Services

Non-pregnant adults age 21 and older

Preventive services, such as prophylaxis and oral debridement, are not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

A prophylaxis, with or without fluoride, is covered two times a calendar year per provider. Oral debridement may be done once per year and in conjunction with a prophylaxis in cases requiring subgingival scaling.

Space maintainers are covered for children.

For children 18 and under, occlusal sealants on the permanent molars and pre-molars (bicuspids) are covered.

1 - 8 Restorative Services

Non-pregnant adults age 21 and older

Restorative services are not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

Composite resin restorations on anterior teeth and the occlusal and buccal surfaces only, amalgam restorations, pin retention, stainless steel crowns, core buildups, prefabricated post and core, and recementation of crowns are covered services.

Medicaid will not reimburse for a permanent stainless steel crown, D2931, and alloy or composite fillings for the same tooth, same date of service. It **is** allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown – permanent.

Porcelain fused to base metal crowns on permanent anterior teeth are covered for children and requires **written prior approval** as described in Chapter 5, Dental Procedure Codes, Restorative Services.

Medicaid will not reimburse for a primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth, same date of service. Bill for one or the other but not both procedures. It is not allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown on a primary tooth.

1 - 9 Endodontics

Non-pregnant adults age 21 and older

Root canal therapy is not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

Root canal therapy is a covered benefit excluding third molars. Second and third molars are also excluded for non-pregnant adults.

Therapeutic pulpotomy is covered for primary teeth only. Root canal therapy for permanent teeth is covered, except on third molars or primary teeth.

First Stage Endodontic Procedures

1. Billing for Completed Root Canal

   Root canals are to be billed after the canals have been completely obturated with the final filling. Billing for services which have not been completed is considered fraud.

   X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.

2. Billing the Patient when Root Canal Incomplete

   When a Medicaid patient has the first stage endodontic procedures done for pain relief and fails to return for subsequent appointments, the dentist cannot bill Medicaid for a completed therapeutic pulpotomy. A provider may bill the Medicaid patient ONLY IF the provider scrupulously follows the process described in SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients. The process requires a written agreement with the patient in advance of treatment. This may also help prevent no-shows for root canal appointments. Two of the exceptions to the prohibition on billing patients are described below:

   A. The dental provider may bill a patient for broken appointments under the conditions specified in SECTION 1, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, are met.
   Briefly, the conditions require a written agreement with the patient regarding broken appointments. Refer to SECTION 1, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, for complete instructions.

   B. The dental provider may bill a Medicaid patient who fails to complete therapeutic pulpotomy when ALL FOUR conditions of SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, are met. For your convenience, those conditions are repeated in Chapter 3, Dental Spend-ups. A dentist who fails to comply exactly with the Medicaid process for billing a patient is disqualified from billing the patient.

   B. A dentist who has the required agreement with the patient may bill the patient under CDT-3 code, D3221, gross pulpal debridement, for the relief of acute pain prior to conventional root canal therapy. Medicaid does not cover code D3221. This is why the dentist may bill the patient for the procedure provided there is the required agreement in place and the patient fails to complete endodontic treatment. **Code D3221 cannot be used by a provider who completes endodontic treatment and bills Medicaid**.

   C. If the dentist has the required agreement with the patient, the dentist may collect the fee for D3221, gross pulpal debridement, at the time of service. The dentist must refund the fee when the root canal was finished and Medicaid is billed.

   D. If the dentist has the required agreement with the patient, did not collect a fee for D3221, Gross pulpal debridement, at the time of service, and the patient fails to return, the dentist may bill the patient for the service.

   E. If the dentist did not obtain the required agreement with the patient in advance of treatment, the dentist may NOT subsequently bill the patient under D3221.

1 - 10 Periodontics

Non-pregnant adults age 21 and older

Periodontics is not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

A gingivectomy for patients who use anticonvulsant medication is a covered service which requires telephone prior authorization. A “gross debridement”, code D4355, is available one time per year and may be billed in conjunction with a prophylaxis on the same date of service.

1 - 11 Prosthodontics

Non-pregnant adults age 21 and older

Prosthodontic services are not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

All denture services described in this chapter require written **prior authorization**. Refer to criteria in Chapter 5, Dental Procedure Codes, Prosthodontics. Medicaid expects prosthetic appliances to last five years. Dentures and partial denture replacements are reimbursable less than five years from the initial placement if necessitated by an extraction.

Prosthodontic services covered:

1. Complete dentures.
2. Immediate dentures.
3. Partial dentures.
4. Relines, D5750 and D5751. Medicaid covers only hard relines completed by a laboratory and will reimburse for only two relines per year per arch.

Medicaid does **not** pay for temporary stayplate partials or temporary dentures.

*** * Additional Requirements For Residents of Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded Who Need Prosthetic Services**

For residents of nursing facilities and Intermediate Care Facilities for the Mentally Retarded, the staff physician *or* nursing facility dental consultant must add documentation supporting medical need and expected results in the patient’s medical record for audit purposes. The additional information should include the following six items:

1. The ability of the patient to adjust to and utilize the denture;
2. The ability of the patient to retain and care for the denture;
3. The patient's desire for a denture;
4. Anticipated result of denture placement, i.e., improved nutrition, improved health, etc.;
5. Assessment of patient's health and nutrition status; and
6. Whether the patient can be expected to wear the denture.

NOTE: The dentures for a nursing home patient must have identification on the appliance to indicate to which patient they belong.

1 - 12 Denture Adjustments, Repairs, Rebases, Relines

Non-pregnant adults age 21 and older

Denture adjustments, repairs, rebases, relines are not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

Denture adjustments are a covered service only when performed by a dentist who did not provide the denture. Other services include: repair broken denture base, repair or replace broken clasps, replace tooth, add tooth, reline denture, and rebase denture.

1 - 13 Oral Surgery

Non-pregnant adults age 21 and older

For non-pregnant adults age 21 and older, Medicaid will reimburse for only an extraction, single tooth, in conjunction with an emergency exam. Refer to Chapter 1 - 5, Diagnostic Services. Use code D7110, Extraction, single tooth, or D7210, Surgical removal of erupted tooth . . . , to bill.

Children, ages 0 through 20 and pregnant women

Extractions are a covered service. Extractions include simple, surgical, soft tissue impactions, partial bony impactions, and full bony impactions.

General dentists may be reimbursed for extractions, incision and drainage, and frenulectomies for ankyloglossia. Some oral surgery codes are only payable to an oral surgeon.

Surgery for emergency treatment of traumatic injury requires prior authorization.

Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus is covered.

1 - 14 Orthodontia

Non-pregnant adults age 21 and older

Orthodontia is not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

All orthodontia requires written prior authorization. The patient must qualify by scoring 30 or more using the "Handicapping Malocclusion Assessment Record" by J. A. Saltzman. Send pre-treatment models, panoramic x-rays, and requested codes on ADA form. Medicaid only covers comprehensive treatment.

Medicaid provides orthodontia services for Medicaid eligible children who have a handicapping malocclusion due to birth defects, accidents, or abnormal growth patterns of such severity that it renders them unable to masticate, digest, or benefit from their diet.

Non-Covered Services

1. Limited orthodontic and removable appliance therapies are not benefits.
2. Removable appliances in conjunction with fixed banded treatment are not covered.
3. Habit control appliances are not a benefit.

1 - 15 Emergency Services

Non-pregnant adults age 21 and older

For non-pregnant adults age 21 and older, Medicaid will reimburse for limited, emergency dental services. These include one limited oral evaluation, problem focused; an intraoral - periapical - first film, and an extraction, single tooth. Refer to Chapters 1 - 5, Diagnostic Services; 1 - 6, Radiographic Services, and 1 - 13, Oral Surgery, for criteria and billing codes.

Children, ages 0 through 20 and pregnant women

Emergency services are reimbursable to dentists and oral/maxillofacial surgeons. If the service requires prior authorization, and authorization cannot be obtained prior to service due to the emergent nature of the services provided, the request and documentation may be submitted immediately following the services. Emergency services may be approved after the service is given when adequate documentation of the emergency is included with the request. The dentist or oral/maxillofacial surgeon shall submit the following documents with the prior authorization request: the operation report, discharge summary, pathology report, x-ray report, and laboratory report if available.

The fee for emergency dental care services is global. It includes necessary laboratory and preoperative work, placement of sutures, packing, removal of sutures and office calls.

1 - 16 Hospitalization for Dental Services

Non-pregnant adults age 21 and older

Hospitalization continues to be covered with prior authorization for non-pregnant adults age 21 and older, but not dental services other than those specified as emergency services. Refer to Chapter 1 - 5, Diagnostic Services.

Children, ages 0 through 20 and pregnant women

Hospitalization to perform dental services is a covered service on an *outpatient basis only*. The provider must document the need for the hospitalization. Refer to Chapter 5, Dental Procedure Codes, General Anesthesia.

1 - 17 I.V. Sedation

Non-pregnant adults age 21 and older

I.V. sedation is not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

I.V. sedation is a covered service and does not require prior authorization when performed by a dentist with state licensure to perform I.V. sedation or by a nurse anesthetist. I.V. sedation requires prior authorization when performed by a nurse anesthetist. I.V. sedation does not include intra oral injections for sedation.

Document in the patient's record the physical or mental disability or other medical condition which necessitates use of I.V. sedation. NOTE: Anxiety does not qualify as a medical condition.

1 - 18 General Anesthesia

Non-pregnant adults age 21 and older

General anesthesia is not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

General anesthesia is a covered service. **Prior authorization** requirements are based on the patient's age and whether or not the patient has a documented physical or mental disability. Criteria are described in Chapter 5, Dental Procedure Codes, General Anesthesia.

General anesthesia for removal of erupted teeth is not a covered service, except when medically necessary.

If an emergent or urgent situation exists, the provider may telephone for a pending request for a prior authorization. The provider must submit the necessary documentation within twenty-one days.

General anesthesia may be performed by a dentist or oral surgeon possessing the proper Class IV permit under State Licensure. The provider may choose to perform his or her own anesthesia with the support staff required by State Licensing or may elect to have another properly licensed individual perform the anesthesia.

1 - 19 Oral Sedation

Non-pregnant adults age 21 and older

Oral sedation is not covered for non-pregnant adults age 21 and older.

Children, ages 0 through 20 and pregnant women

Medicaid covers intramuscular and intra oral injections for sedation only under code D9248, non-intravenous conscious sedation, which includes the sedative drug. Behavior management, D9920, is **not** covered. Nitrous Oxide analgesia is **not** covered. Oral sedation medications are covered under the Medicaid pharmacy program by prescription only, but oral sedation under code D9630, is **not** covered.

1 - 20 After Hours Office Visit

Code D9440, Office visit, after regularly scheduled hours, is allowed for use for visits occurring after the regular business day (8 a.m. to 5 p.m.), typically in connection with an emergency appointment. If an appointment is scheduled in the course of normal business procedures, it is not allowed under this code. This includes lunch, afternoons breaks, and visits after normal hours when the dentist sees the patient following the normal closing hour. This code may be used only in a situation where the dentist is called away from home to return to the office in the evening, night or early morning, or a non-business day, when staff is not present to treat an emergency condition which can not be scheduled. Scheduled appointments are not allowed reimbursement under this code.

2 NON-COVERED SERVICES

Medicaid does **NOT** cover the following dental services:

1. Multiple surface composite resin fillings on posterior teeth
2. Cast crowns (porcelain fused to metal) on posterior permanent teeth or on primary teeth
3. Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex.
4. Root canal therapy on primary teeth or permanent third molars, and second molars for non-pregnant adults
5. Fixed bridges or pontics
6. Dental implants, including but not limited to endosteal implants, eposteal implants, transosteal implants, subperiosteal implants
7. Tooth transplantation
8. Ridge augmentation
9. Osteotomies
10. Vestibuloplasty
11. Alveoloplasty
12. Occlusal appliances, habit control appliances or interceptive orthodontic treatment
13. Treatment of temporomandibular joint syndrome or its prevention, sequela, subluxation, therapy, arthrostomy, meniscectomy or condylectomy
14. House calls
15. Consultation or second opinions not requested by Medicaid
16. Processing claim forms
17. Charges for laboratory tests or pathology reports (The laboratory or pathologist must bill the charges directly to Medicaid.)
18. Services which require a prior authorization and are provided before the prior authorization is given. However, this exclusion does not apply to an emergency service which meets the conditions of Chapter 1 - 14, Emergency Services.
19. General anesthesia for removal of an erupted tooth.
20. Periodontal scaling, root planing, and periodontal surgery.

21. Oral sedation and behavior management fees. Medicaid will pay a pharmacy to dispense orally administered medications.

22. Temporary dentures or temporary stayplate partial dentures

23. Maxillary or Mandibular frenectomies.

24. Limited orthodontic treatment, including removable appliance therapies.

25. Removable appliances in conjunction with fixed banded treatment.

26. Habit control appliances.

3 DENTAL SPEND-UPS

Medicaid clients in the dental program may choose to upgrade a covered service to a non-covered service if they assume the responsibility for the difference in the fees for the covered and non-covered services.

The only dental procedures which a Medicaid client may choose to upgrade are as follows:

- Covered amalgam fillings to non-covered composite resin fillings
- Covered stainless steel crowns to non-covered porcelain or cast gold crowns
- Covered anterior stainless steel crowns (deciduous) to non-covered anterior stainless steel crowns with facings (composite facings added or commercial or lab prepared facings)

Patient Choice of a Non-Covered Service which is an Upgrade from a Covered Service.

Generally, a provider may not bill a Medicaid patient for the difference between the Medicaid payment and the provider's usual and customary fee, as the Medicaid payment is considered payment in full. However, when a patient requests a service not covered by Medicaid, such as a non-covered composite resin filling instead of a covered silver filling, a provider may bill the Medicaid patient when ALL FOUR conditions of SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, are met. For your convenience, those conditions are repeated below:

a. The provider has an established policy for billing all patients for services not covered by a third party. (The charge cannot be billed only to Medicaid patients.)
b. The patient is advised prior to receiving a non-covered service that Medicaid will not pay for the service.
c. The patient agrees to be personally responsible for the payment.
d. The agreement is made in writing between the provider and the patient which details the service and the amount to be paid by the patient.

The patient makes the choice. The dentist cannot mandate nor insist the covered procedure be upgraded.

Unless all four conditions are met, the provider may not bill the patient for the non-covered service, even if the provider chooses not to bill Medicaid. Further, the patient's Medicaid Identification Card may not be held by the provider as guarantee of payment by the patient, nor may any other restrictions be placed upon the patient.

The amount paid by the patient is **the difference between the provider's usual and customary charge for the non-covered service and the provider's usual and customary charge for the covered service**. For example, if the usual and customary charge for a two surface amalgam filling is $50, and the patient wants a two surface composite filling with the regular fee of $75, the patient would be responsible to pay an additional $25.

The amount the patient must pay is **not** the difference between the Medicaid payment for the service and the usual and customary fee for the requested upgraded service. For example, Medicaid pays $39.60 for a two surface amalgam filling, even though the provider's usual and customary charge might be $50. The provider accepts $39.60 as payment in full and cannot bill the patient for the $10.40 difference between the Medicaid fee and the usual and customary fee. If the patient wants a two surface composite filling with the regular fee of $75, the patient would be responsible to pay the difference of an additional $25. The patient is **not** responsible to pay the difference between the Medicaid payment for the covered service and the usual and customary fee for the requested upgraded service. (In this example, the patient is **not** responsible to pay the difference of $35.40 between the Medicaid payment of $39.60 and the usual and customary fee of $75.00.)

4 DENTAL INCENTIVE PROGRAMS

Effective July 1, 1997, Medicaid began new reimbursement programs for dentists. The programs are the result of an increase in funding from the 1997 legislature and recommendations made to Medicaid by a Dental Task Force composed of dentists, Medicaid staff, and client representatives. The intent of the programs is to increase access to dental service and reward dentists who treat a significant number of Medicaid clients.

A. Dental Providers in Urban Counties

Urban counties include those in the Wasatch front: Salt Lake, Weber, Davis, and Utah Counties. Medicaid will increase the reimbursement on all covered services by 20% for participating urban providers who are willing to treat 100 or more individual Medicaid clients in the course of a year.

Certain dentists may already be above the 100 clients in a year level. Dentists in this group will receive the 20% increase automatically. Remember, 100 Medicaid clients per year is only two per week. Other dentists who are willing to sign an agreement to see 100 or more Medicaid clients during the next year will also receive the 20% for all services.

The 20% differential increase began with Medicaid eligible services performed after July 1, 1997. Semiannually, Medicaid will track the clients being treated and will notify dentists by letter if there will be any change in their reimbursement rates. Providers must treat 50 Medicaid eligible individuals each six months, which averages only two (2) patients per week, to remain eligible. If a dentist falls behind in these averages, he will lose the 20% increased payment differential until he brings the level of service up to the required level and reapplies for the differential.

Oral surgeons are exempt from the 100 patient minimum if they agree to be on a referral list available to dentists and Medicaid staff. To receive the 20% increase, they must sign and return the Medicaid agreement letter on which they agree to accept Medicaid referrals.

B. Dental Providers in Rural Counties

Dentists outside of the Wasatch front (which includes all counties EXCEPT Salt Lake, Weber, Davis, and Utah Counties) automatically receive a 20% increase in reimbursement. This increase is to encourage dentists in rural areas to treat Medicaid clients and thereby improve access for clients residing outside of the Wasatch front areas.

C. The increases outlined in paragraphs A and B are mutually exclusive. A dentist in one of the four Wasatch Front counties can get a 20% increase by seeing the designated number of Medicaid clients. Dentists in other counties will receive a 20% increase regardless of the number of Medicaid patients.

D. Bill your usual and customary fee for a dental service provided to a Medicaid client. If you have signed the Medicaid dental agreement, you will receive either 120% of the amount listed on the reimbursement schedule or the amount you billed for the service provided, whichever amount is less.

E. The Agreement Letter is included with this manual. If you wish to sign up for the 20% incentive immediately, you may fax a completed copy of the attached agreement to Medicaid at 1-801-538-6805.

MEDICAID AGREEMENT LETTER

DENTIST

I agree to provide eligible dental services to an average of two (2) Medicaid eligible clients per week. I recognize that this agreement will result in an increase in the Medicaid payment amount of 20% for services rendered on or after July 1, 1997, and that initially these payments will be made on a prospective basis based on my Medicaid payments for the previous quarter.

Payment of the additional 20% will begin for the payment cycle after this signed agreement has been received by the Bureau of Medicaid. Rural providers are not eligible for the additional 20% volume payment, they will receive an automatic 20% because they are providing services in a rural area.

_____ _____

Dentist's Signature Date

_____

Medicaid Provider Number

ORAL SURGEON

I agree to have my name included on a referral list for Medicaid clients, and will accept Medicaid referrals. I understand that this agreement will result in a 20% increase on the Medicaid payment schedule for all Medicaid client services. Rural providers are not eligible for the additional 20% referral list payment, they will receive an automatic 20% because they are providing services in a rural area.

_____

Oral Surgeon's Signature Date

_____

Medicaid Provider Number

Please return signed form to:

Medicaid Provider Enrollment
Box 143106
Salt Lake City UT 84114-3106

Fax line 538-6805

IF YOU ARE NOT CURRENTLY A MEDICAID PROVIDER AND WISH TO APPLY TO BE ONE, PLEASE CALL the Medicaid Information Line: 538-6155 or 1-800-662-965.

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5 DENTAL PROCEDURE CODES, LIMITS AND CRITERIA

5 - 1 Table Headings Defined

Code The code is the Health Common Procedure Code System (HCPCS) code used by Medicaid to identify the item or the "Y" code assigned by Medicaid. The procedure codes listed are the only ones accepted by Medicaid. Medicaid replaces the initial '0' of the ADA dental codes with a 'D'. For example, the ADA code 00120 is equivalent to the Medicaid code D0120. Refer to the code tables which follow.

Age, PG "0 - 20" : This entry in the **Age, PG** column means payment will be made only if :
(1) the patient's age on the date of service falls within the age range specified [For example, "0 - 20" means from birth through age 20]
OR
(2) the patient is a pregnant woman.

"all": This entry in the **Age, PG** column means Medicaid covers the service or procedure from birth through any age, including non-pregnant adults.

Criteria The criteria listed are required by Medicaid before the item will be reimbursed and include criteria used by Medicaid staff to review a request for prior authorization.

Limits Any limits applicable to a procedure code.

P A **P A**, Prior Authorization, is approval given by the Division of Health Care Financing prior to dental services being rendered. If Prior Authorization is required for a procedure, code letter **T** or **W** will be in the P A column. If there is no letter in this column, prior authorization is not required. Refer to the Utah Medicaid Provider Manual, SECTION 1, Chapter 9, Prior Authorization, for additional information, on the prior approval process.

When a dental code requires prior authorization, the procedure must be authorized by Medicaid BEFORE the service is given, except for emergency services. For authorization of emergency services, refer to Chapter 1 - 14, Emergency Services.

T - Telephone Prior Authorization: Call Medicaid Information and follow the telephone menu prompts. In the Salt Lake City area, call **538-6155**.
In Utah, Idaho, Wyoming, Colorado New Mexico, Arizona, and Nevada, call toll-free: **1-800-662-9651**.
From other states, call **1-801-538-6155**.

W - Written Prior Authorization: Send written requests to:

MEDICAID PRIOR AUTHORIZATION
BOX 143103
SALT LAKE CITY UT 84114-3101

or use FAX NUMBER: **(801) 538-6382**

Coding Notes

Codes newly added to the list are in bold print.
A vertical line in the margin indicates where text or a descriptor changed for an existing code.
An asterisk (*) marks where a code is newly removed.

DIAGNOSTIC SERVICES

References: Chapter 1 - 5, Diagnostic Services
Chapter 1 - 15, Emergency Services

Code	Description	Age, PG	Criteria	PA	Limits
D0120	Periodic oral evaluation	0 - 20			Two per calendar year per provider, or one per calendar year per provider in addition to a comprehensive oral evaluation.
D0140	Limited oral evaluation - problem focused (previously code D0130, emergency exam)	all	Allows the dentist to be paid for examining, prescribing or referring the patient.		
D0150	Comprehensive oral evaluation (previously code D0110, initial exam)	0 - 20			One time only per provider

RADIOGRAPHS

Reference: Chapter 1 - 6, Radiographic Services

Code	Description	Age, PG	Criteria	PA	Limits
D0210	Intraoral - complete series (including bitewings)	0 - 20			
D0220	Intraoral - periapical - first film	all			1. Medicaid considers it standard practice to bill for a full mouth series if more than 12 periapicals are taken during a single visit. 2. Any periapical x-rays billed additionally with D0210 will be rebundled and considered part of the full mouth series. 3. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
D0230	Intraoral - periapical - each additional film	0 - 20			
D0270	Bitewing - single film	0 - 20			
D0272	Bitewings - two films	0 - 20			
D0274	Bitewings - four films	0 - 20			

D0330	Panoramic film	0 - 20			1. May be billed with bitewings. 2. A panoramic x-ray with more than bitewings, 2 or 4 films, plus 2 periapicals will rebundle to D0210. 3. Panoramic x-rays and full series x-rays should not be taken more often than one every two years unless there is specific dental diagnostic need documented in the patient's records.

PREVENTIVE SERVICES

Reference: Chapter 1 - 7, Preventive Services

Code	Description	Age, PG	Criteria	PA	Limits
D1110	Prophylaxis - adult	16 & up			Two per calendar year
D1120	Prophylaxis - child	0 - 20			Two per calendar year, with or without fluoride
D1201	Topical application of fluoride (including prophylaxis) - child	0 - 20			
D1351	Sealant - per tooth	0 - 18	1st and 2nd permanent molars or premolars (bicuspids)		
D1510	Space maintainer - fixed - unilateral	0 - 20			
D1515	Space maintainer - fixed - bilateral	0 - 20			
D1520	Space maintainer - removable - unilateral	0 - 20			
D1525	Space maintainer - removable - bilateral	0 - 20			

RESTORATIVE SERVICES

Reference: Chapter 1 - 8, Restorative Services

Code	Description	Age, PG	Criteria	PA	Limits
D2110	Amalgam - one surface, primary	0 - 20			
D2120	Amalgam - two surfaces, primary	0 - 20			
D2130	Amalgam - three surfaces, primary	0 - 20			
D2131	Amalgam - four or more surfaces, primary	0 - 20			
D2140	Amalgam - one surface, permanent	0 - 20			
D2150	Amalgam - two surfaces, permanent	0 - 20			
D2160	Amalgam - three surfaces, permanent	0 - 20			
D2161	Amalgam - four or more surfaces, permanent	0 - 20			
D2330	Composite resin - one surface anterior	0 - 20			Primary or permanent anterior teeth only
D2331	Composite resin - two surfaces anterior	0 - 20			Primary or permanent anterior teeth only
D2332	Composite resin - three surfaces anterior	0 - 20			Primary or permanent anterior teeth only
D2335	Composite resin - four or more surfaces	0 - 20			Primary or permanent anterior teeth only
D2380	Composite resin- one surface posterior, primary teeth	0 - 20			Limited to occlusal and buccal surfaces
D2385	Composite resin- one surface posterior permanent teeth	0 - 20			Limited to occlusal and buccal surfaces
D2751	Crown - porcelain fused to base metal crown, permanent anterior teeth	0 - 20	Provider must send 1. Completed ADA form and 2. Periapical x-rays	W	Permanent anterior teeth only
D2920	Re-cement crown	0 - 20			

Code	Description	Age, PG	Criteria	PA	Limits
D2930	Prefabricated stainless steel crown - primary teeth	0 - 20	Medicaid will not reimburse for a primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth, same date of service. Bill for one or the other but not both procedures. It is not allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown on a primary tooth.		Teeth letters A - T
D2931	Prefabricated stainless steel crown - permanent teeth	0 - 20	Medicaid will not reimburse for a permanent stainless steel crown, D2931, and alloy or composite fillings for the same tooth, same date of service. It is allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown – permanent.		Teeth numbers 2 - 15 and 18 - 31
D2950	Core build-up including any pins	0 - 20			Teeth numbers 2 - 15 and 18 - 31
D2951	Pin retention per tooth in addition to restoration	0 - 20			Teeth numbers 2 - 15 and 18 - 31
D2954	Prefabricated post and core in addition to crown	0 - 20			Teeth numbers 2 - 15 and 18 - 31
D2980	Crown repair, by report	0 - 20			

ENDODONTICS

Reference: Chapter 1 - 9, Endodontics

Code	Description	Age, PG	Criteria	PA	Limits
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament	0 - 20			Primary teeth only
D3310	Endodontic therapy - Anterior, excluding final restoration	0 - 20			Permanent teeth
D3320	Endodontic therapy - Premolar (bicuspid), excluding final restoration	0 - 20			Permanent teeth
D3330	Endodontic therapy - Molars, excluding final restoration	0 - 20			Root canal therapy is a covered benefit excluding third molars. Second and third molars are also excluded for pregnant women. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
D3410	Apicoectomy - anterior	0 - 20			
D3421	Apicoectomy - bicuspid (first root)	0 - 20			
D3425	Apicoectomy - molar (first root)	0 - 20			Excludes permanent third molars for children and second and third molars for pregnant women.
D3426	Apicoectomy - each additional root including retrofill	0 - 20			Excludes permanent third molars for children and second and third molars for pregnant women.
D3430	Retrograde filling - per root	0 - 20			Excludes permanent third molars for children and second and third molars for pregnant women.

PERIODONTICS

Reference: Chapter 1 - 10, Periodontics

Code	Description	Age, PG	Criteria	PA	Limits
D4210	Gingivectomy or Gingivoplasty - per quadrant	0 - 20	For drug-induced gingival hyperplasia only. (Dilantin and Cyclosporin)	T	
D4355	Full mouth debridement, periodontal evaluation	0 - 20	Not to be billed in conjunction with prophylaxis. Must have subgingival calculus present	T	Oral debridement may be done once per year and in conjunction with a prophylaxis in cases requiring subgingival scaling.

PROSTHODONTICS

References: Chapter 1 - 11, Prosthodontics
Chapter 1 - 12, Denture Adjustments, Repairs, Rebases, Relines
Chapter 1 - 15, Emergency Services

Code	Description	Age, PG	Criteria	PA	Limits
NOTE: For residents of nursing facilities and Intermediate Care Facilities for the Mentally Retarded, refer to additional information to be included with prior authorization in Chapter 1 - 11, Prosthodontics. Medicaid expects removable appliance to last at least five years before replacement.					
D5110	Complete denture - maxillary (includes routine post-delivery care)	0 - 20	Provider must know age of dentures and reasons dentures cannot be repaired or relined. Replacement is not a benefit when: 1. Due to neglect or abuse of the existing denture OR 2. The existing denture can be relined for proper fit.	T	Dentures less than five years old should be repaired or relined.
D5120	Complete denture - mandibular (includes routine post-delivery care)	0 - 20	Same as D5110 above.	T	Same as D5110 above
D5130	Immediate denture - maxillary (includes routine post-delivery care	0 - 20	Prior authorization must be obtained before removing teeth in preparation for the immediate denture. Provider must send: 1. Completed ADA form and 2. Panorex or full mouth mounted periapical x-rays.	W	
D5140	Immediate denture - mandibular (includes routine post-delivery care)	0 - 20	Same as D5130 above.	W	
D5211	Maxillary partial denture - resin base, (including clasps, rests, and teeth) "Flipper"	0 - 20	1. Prior authorization must be obtained before fabricating the partial denture. 2. There must be an anterior tooth missing or the partial denture must restore mastication ability. 3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 5. Provider must send the following: A. Completed ADA form identifying missing teeth;	W	Non-emergency

Code	Description	Age, PG	Criteria	PA	Limits
			B. Mounted periapical x-rays or Panorex; C. List of teeth to be replaced.		
D5211	Maxillary partial denture - resin base, (including clasps, rests, and teeth) "Flipper"	0 - 20	Same criteria as D5211 above, Non-Emergency, PLUS one of the following: 1. Tooth is fractured or avulsed, or 2. Abscess requires immediate removal of tooth. Telephone authorization to be followed by submittal of x-rays with the claim.	T	Emergency - anterior #6-11 only
D5212	Mandibular partial denture - resin base, (including clasps, rests, and teeth) "Flipper"	0 - 20	Same criteria as D5211 above, Non-Emergency.	W	Non-Emergency
D5212	Mandibular partial denture - resin base, (including clasps, rests, and teeth) "Flipper"	0 - 20	Same criteria as D5211 above, Emergency.	T	Emergency - anterior #22-27 only
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0 - 20	1. Prior authorization must be obtained before fabricating the partial denture. 2. There must be an anterior tooth missing or the partial denture must restore mastication ability. 3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4. There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6. Provider must send the following: A. Completed ADA form identifying missing teeth; B. Mounted periapical x-rays or Panorex; C. List of teeth to be replaced.	W	
D5214	Mandibular partial denture -	0 - 20	Same criteria as D5213	W	

Code	Description	Age, PG	Criteria	PA	Limits
D5410	Adjust complete denture - maxillary	0 - 20	Payable to dentist who did not originally provide the denture.		May be payable to originating dentist six months post delivery
D5411	Adjust complete denture - mandibular	0 - 20	Payable to dentist who did not originally provide the denture.		May be payable to originating dentist six months post delivery
D5421	Adjust partial denture - maxillary	0 - 20	Payable to dentist who did not originally provide the denture.		May be payable to originating dentist six months post delivery
D5422	Adjust partial denture - mandibular	0 - 20	Payable to dentist who did not originally provide the denture.		May be payable to originating dentist six months post delivery
D5510	Repair broken complete denture base	0 - 20			
D5520	Replace missing or broken teeth - complete denture (each tooth)	0 - 20			
D5630	Repair or replace broken clasp	0 - 20			
D5640	Replace broken or missing tooth - per tooth (partial denture)	0 - 20			
D5650	Add tooth to existing partial denture	0 - 20			
D5710	Rebase complete maxillary denture	0 - 20			
D5711	Rebase complete mandibular denture	0 - 20			
D5750	Reline complete maxillary denture (laboratory)	0 - 20	Medicaid covers only hard relines completed by a laboratory. It is difficult to establish a time for a reline following an immediate denture, but typically, hard relines should be delayed until bone resorption has stabilized following the extractions which would be 6 to 12 months following the extractions.		Medicaid will not pay for more than two relines per year per arch.
D5751	Reline complete mandibular denture (laboratory)	0 - 20	See criteria above.		See limit above.
D5760	Reline maxillary partial denture (laboratory)	0 - 20			
D5761	Reline mandibular partial denture (laboratory)	0 - 20			

ORAL SURGERY SERVICES

Reference: Chapter 1 - 13, Oral Surgery

Code	Description	Age, PG	Criteria	PA	Limits
D7110	Extraction, single tooth	all			
D7120	Extraction, each additional tooth, at the same visit	0 - 20			
D7130	Root removal - exposed roots	0 - 20			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of the tooth	all			
D7220	Removal of impacted tooth - soft tissue	0 - 20			
D7230	Removal of impacted tooth - partially bony	0 - 20			
D7240	Removal of impacted tooth - completely bony	0 - 20			
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus	0 - 20			
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	0 - 20			
D7281	Surgical exposure of impacted or unerupted tooth in order to aid eruption	0 - 20			
D7286	Biopsy of oral tissue - soft (all others)	0 - 20			
D7430	Excision, benign tumor, diameter up to 1.25 cm	0 - 20			
D7471	Removal of exostosis - per site	0 - 20	Must be done in conjunction with a new denture or partial denture fabrication	W	
D7510	Incision and drainage of abscess - intraoral soft tissue	0 - 20			
D7960	Fenulectomy (Fenectomy)	0 - 20	Ankyloglossia (lingual only)	T	
D9310	Consultation	0 - 20			
D9420	Hospital Call	0 - 20		T	

ORTHODONTICS

Reference: Chapter 1 - 14, Orthodontia

Code	Description	Age, PG	Criteria	PA	Limits
D0470	Study models (for orthodontic request only)	0 - 20			
D8080	Comprehensive orthodontic treatment of the adolescent dentition (global fee covering all modalities during treatment)	0 - 20	Provider must send: 1. Prior authorization ADA form, 2. Trimmed study models and wax bite, and 3. Panorex X-ray if there are missing/impacted teeth.	W	
D8670	Periodic orthodontic treatment visit (global fee covering all modalities during treatment)	0 - 20	Prior authorized with D8080 above, quarterly, eight times in two years.	W	
D8680	Orthodontic retention	0 - 20	Prior authorized at the completion of orthodontic treatment	W	
D8690	Completion of fixed appliance therapy by other than banding dentist	0 - 20	Provider must send 1. Prior authorization ADA form, 2. Letter of medical need, 3. Trimmed pretreatment models and current models, and 4. X-rays if there are missing/impacted teeth.	W	
D8692	Replacement Retainer	0 - 20	This service is limited to one per lifetime for those who are receiving orthodontic treatment paid by Utah Medicaid.		Not payable as initial retainer
D8999	Unspecified orthodontic procedure, by report	0 - 20	Provider must send: 1. Prior authorization form or ADA form, 2. Letter of medical need, 3. Trimmed study models and wax bite, and 4. X-rays.	W	

I.V. SEDATION

Reference: Chapter 1 - 17, I.V. Sedation

Code	Description	Age, PG	Criteria	PA	Limits
D9241	I.V. sedation, all ages, by oral surgeons in an office setting	0 - 20	Document in the patient's record the physical or mental disability or other condition which necessitates use of I.V. sedation. Anxiety does not qualify as a medical condition.		Prior authorization is not required when service is performed by a dentist with state licensure to perform I.V. sedation.
Y1800	Dental I.V. sedation by nurse anesthetist in an office setting	0 - 20	The patient must have a physical or mental disability or other documented condition which justifies the use of I.V. sedation. Anxiety does not qualify as a medical condition. The provider must send: 1. A completed ADA form describing the condition to justify the use of I.V. sedation and 2. X-rays when applicable. 3. Include nurse anesthetist's Medicaid provider number.	W	

I.M. or INTERORAL SEDATION

Reference: Chapter 1 - 19, Oral Sedation

Code	Description	Age, PG	Criteria	PA	Limits
D9248	Non-intravenous conscious sedation	0 - 20	The code is covered for intramuscular and intra oral injections for sedation only and includes the sedative drug. Document in the patient's record the physical or mental disability or other condition which necessitates use of I.V. sedation. Anxiety does not qualify as a medical condition.		Prior authorization is not required when service is performed by a dentist with state licensure to perform I.V. sedation.

GENERAL ANESTHESIA

References: Chapter 1 - 18, General Anesthesia
Chapter 1 - 16, Hospitalization

Code	Description	Age, PG	Criteria	PA	Limits
D9220	General anesthesia first 30 minutes, in office	0 - 4	For patient 4 years of age or younger, prior approval is not required.		
D9220	General anesthesia first 30 minutes, in office	5 - 20	Patient is at least 5 years of age with a physical or mental disability. Document the physical or mental disability which justifies the use of general anesthesia.	T	
D9220	General anesthesia first 30 minutes, in office	5 - 8	Patient is 5 - 8 years of age and without physical or mental disability, the patient must have a documented condition such as a failure and inability to treat when using a pre-medication which justifies the use of general anesthesia.	T	
D9220	General anesthesia first 30 minutes, in office	9 - 20	Patient is at least 9 years of age and without physical or mental disability, the patient must have a documented condition such as such as a failure and inability to treat when using a pre-medication which justifies the use of general anesthesia, OR in conjunction with the extraction of a partial or full boney impacted third molar. 1. A completed ADA form with a proposed treatment plan, and 2. X-rays when applicable.	W	
D9221	General anesthesia, additional 15 minutes, in office	0 - 20			Must be billed in conjunction with D9220 above.

Code	Description	Age, PG	Criteria	PA	Limits
Y1899, dental general anesthesia, is to be used by anesthesiologists and surgical centers for the facility charge for all patients. Please note the prior approval requirements for each age group. Anesthesiologists using Y1899 must follow the billing instructions in the Utah Medicaid Provider Manual for Physician Services, SECTION 3, Anesthesiology.					
Y1899	Dental general anesthesia: hospital, surgical center, or facility charge	0 - 4	For patient 4 years of age or younger, prior approval is not required.		
Y1899	Dental general anesthesia: hospital, surgical center or facility charge	5 & older	Patient 5 years of age or older with a physical or mental disability. Document the physical or mental disability which justifies the use of general anesthesia.	T	
Y1899	Dental general anesthesia: hospital, surgical center or facility charge	5 - 8	Patient 5-8 years of age and without a physical disability. The patient must have a documented condition, such as a treatment failure and/or the inability to treat when using a pre-medication, which justifies the use of general anesthesia.	T	
Y1899	Dental general anesthesia: hospital, surgical center or facility charge	9 & older	Patient 9 years of age or older and without physical or mental disability. The patient must have a documented condition, such as a treatment failure and/or inability to treat when using a pre-medication, which justifies the use of general anesthesia. Not applicable for third molar removal. The provider must send the following: 1. A completed ADA form with a proposed treatment plan requesting a hospital setting, and 2. X-rays when applicable.	W	

OTHER PROCEDURES

Reference: Chapter 1 - 20, After Hours Office Visit

Code	Description	Age, PG	Criteria	PA	Limits
D9440	Office visit - after regularly scheduled hours	0 - 20	For use only in a situation where the dentist is called away from home to return to the office in the evening, night or early morning, or a non-business day, when staff is not present to treat an emergency condition which can not be scheduled.		Document time in patient's record
D9999	Unspecified adjunctive procedure, by report	0 - 20		T	

SECTION 2 INDEX
Alphabetical

SECTION 2 INDEX
Numerical by Code